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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

GERTRUDE M. STUART and FERNAND DANIS,
Petitioners,

vs.

METROPOLITAN LIFE INSURANCE COMPANY,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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QUESTIONS PRESENTED

1. Is the Employee Retirement Income Security Act's (ERISA) delegation of quasi-judicial decisionmaking authority to fiduciaries who have a direct financial stake in the decisions they are charged with making unconstitutional?[1]

2. Is the constitutional guarantee of due process violated when a Court applies the deferential arbitrary and capricious standard of review to claims decisions of ERISA fiduciaries who have a direct financial interest in the outcome of the decisions they make?

3. Does ERISA, in fact, permit entitites whose financial interests are in direct conflict with the interests of plan claimants to act as fiduciaries, and if so, what is the proper standard of review for the decisions of self-interested fiduciaries?

4. Does an insurers recoupment of money from an insured to offset the receipt by that insured of a lump-sum retroactive Social Security payment violate the anti-alienation provision of the Social Security Act, 42 U.S.C. § 407?

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[1] This case involves essentially the same factual situation and ultimate issue presented by *Firestone Tire & Rubber Company v. Bruch,* No. 87-1054, which this Court will consider this term. The central question in this case and in *Bruch* is how to resolve the problem of the financially self-interested ERISA fiduciary. Unfortunately, it appears that the parties in *Firestone Tire & Rubber Co. v. Bruch,* supra, have not asked the serious constitutional questions concerning the delegation of decision making authority to financially self-interested ERISA fiduciaries who are charged with making initial claims decisions and providing a "full and fair review" of denied claims. 29 U.S.C. § 1133(2). The Court may, therefore, in its discretion wish to hear this case with *Bruch* in order to avoid having its consideration of a problem which clearly needs resolution artifically restricted by the narrowness of the arguments presented in *Bruch.*

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

The petitioners, Gertrude M. Stuart and Fernand Danis, hereby petition for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the First Circuit entered in this case on July 7, 1988. The petitioners seek to challenge the judgment of the First Circuit on the ground that the judicial deference the District Court initially, and by its subsequent affirmation the First Circuit Court of Appeals, accorded the decision of an insurer with a direct financial interest in the results of its own decision making deprived the petitioners of due process of law guaranteed to them under the Constitution of the United States. Petitioners also contend that when the Federal Government paid them a lump-sum Social Security award, the respondent, Metropolitan Life Insurance Company, recouped from them an approximately equal and offsetting amount of money in violation of the anti-alienation provision of the Social Security Act, 42 U.S.C. § 407.

OPINIONS BELOW

The opinion of the Court of Appeals summarily affirming the opinion of the District Court is reprinted in the appendix as is the judgment of the Court of Appeals. The opinion of the District Court is reported at 664 F.Supp. 619 (D. Me. 1987) and is reprinted in the appendix as is the judgment of the District Court.

JURISDICTION

This Court has jurisdiction to review the judgment of the Court below by writ of *certiorari* pursuant to 28 U.S.C. § 1254(1). The judgment of the Court of Appeals was entered on July 7, 1988 and this petition for *certiorari* is being filed within 90 days of the entry of that judgment.

APPLICABLE STATUTES

The most relevant sections of the Employee Retirement Income Security Act of 1974 are 29 U.S.C. § 1002(21)(a) and 29 U.S.C. § 1106(b)(1) and (2) and 29 U.S.C. § 1133(2).

29 U.S.C. § 1002(21(A) reads:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under § 1105(c)(1)(B) of this title.

29 U.S.C. § 1106(b) states:

A fiduciary with respect to a plan shall not —

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

29 U.S.C. § 1133(2) reads:

In accordance with regulations of the Secretary, every employee benefit plan shall —

. . .

(2) afford a reasonable opportunity to any participants whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

The relevant portion of the United States Constitution upon which the Petitioners rely is the due process clause of Article V which states:

No person shall . . . be deprived of life, liberty or property, without due process of law; . . .

Finally, the relevant section of the Social Security Act upon which Petitioners rely is the anti-alienation section, 42 U.S.C. § 407 which reads:

(a) The right of any person to any future payment under this subchapter shall not be transferrable or assignable, at

law or in equity, and none of the monies paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process or to the operation of any bankruptcy or insolvency law.

(b) No other provision of law, enacted before, on, or after April 20, 1983, may be construed to limit, supercede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

STATEMENT OF THE CASE

This petition arises from the First Circuit's summary affirmation of a District Court decision denying the Plaiftiffs' claims that Metropolitan Life Insurance Company's recoupment of money from them in response to their receipt of a lump-sum retroactive Social Security payment was not provided for anywhere in the relevant contract of insurance, and even if there had been such a contract provision, it violated the anti-alienation provision of the Social Security Act, 42 U.S.C. § 407. The Plaintiffs, former employees of General Electric, had purchased long-term disability insurance from Metropolitan Life Insurance Company under a group policy obtained by General Electric. The choice to obtain long-term disability insurance was entirely elective and the insurance was paid for entirely by the employees who chose to purchase it. The decision to purchase the insurance was made by the Plaintiffs based on representations made to them by General Electric and Metropolitan.

The Plaintiffs became disabled and applied for long-term disability benefits under the Metropolitan Insurance coverage they had elected to purchase through weekly payroll deductions. Stuart and Danis also applied for Federal Social Security disability benefits.

When Stuart and Danis were subsequently awarded Social Security benefits their first payment was in the form of a retroactive lump-sum check. Upon learning of the receipt by Stuart and Danis of the lump-sum Social Security payment, Metropolitan demanded that Stuart and Danis pay to it an offsetting amount of money roughly equal to the individual lump-sum Social Security award payment received by Stuart and Danis (certain cost of living adjustments and payments to other family members were excluded).

Metropolitan in essence was requesting that the Petitioners turn over their retroactive Social Security money directly to Metropolitan. They had never understood their insurance contract to call for such a retroactive offset and, at least in Stuart's case (William Stuart died during the pendency of this litigation and his wife, Gertrude Stuart, is substituted for him as his personal representative) the money received from the Social Security Administration was largely spent by the time Metropolitan made its demand for repayment.

The Court analyzed the contract documents at issue and Metropolitan's claim that it was entitled to recoup an offsetting amount of money from its insureds when they received a Social Security payment under the deferential arbitrary and capricious standard of review. The District Judge stated:

> "An action brought pursuant to 29 U.S.C. § 1132(a)(1)(b) (1982) for benefits due under a pension plan requires the Court to review the plan administrator's determination under an 'arbitrary and capricious' standard." 644 F.Supp. 619, 622.

After analyzing the contract language under this standard and finding it to be "legally correct" (a question begging characterization which naturally depends on what standards and principles are applied in the first place) the Court concluded that Metropolitan's recoupment of benefits was not arbitrary and capricious. 664 F.Supp. 619, 624. That review under the

arbitrary and capricious standard makes a significant difference is made clear from a comparison between this case and *Bush v. Metropolitan Life Ins. Co.*, 656 F2d. 231 (6th Cir. 1981) in which the Sixth Circuit reached a different result after analyzing essentially the same contract language using common law contract principles.

Stuart and Danis contend that a close reading of the Court's opinion clearly reveals that it found authority for recoupment primarily in the existence of a reimbursement agreement presented to the petitioners after they became disabled and after Metropolitan's contract obligations were fixed. A review of the actual contract language (as the District Court appears to concede) contains no provision whatsoever for recoupment and it was only the District Court's extention of that language to cover recoupment that permitted Metropolitan to prevail. It is this deference, inevitable under the arbitrary and capricious standard of review, that denied Petitioners due process of law.[2]

The District Court limited its review to determining whether Metroploitan's recoupment of money from the Petitioners was arbitrary and capricious notwithstanding that such deferential and limited review of the actions of a self-interested fiduciary made that fiduciary the judge of its own case and deprived Petitioners of due process of law. We have included the relevant portions of the petitioners District Court brief as evidence that the Constitutional issue was appropriately raised at the District Court level. (Appendix at 31-34.)

The Court below also rejected the arguments of Stuart and Danis that Metropolitan's recoupment of money from its insureds was merely a kind of disguised shell game in which it had assigned to itself the right to a future Social Security payment in contravention of 42 U.S.C. Section 407 which prevents such transfers or assignments of Federal Social Security benefits.

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[2] The arbitrary and capricious standard of review is deferential both by definition and by judicial interpretation. See *Bruch v. Firestone Tire and Rubber Co.*, 828 F.2d 134 (3rd Cir. 1987).

REASONS FOR GRANTING THE WRIT

There is one reason which stands above all others for granting the writ of *certiorari* in this case. This Court will hear *Firestone Tire & Rubber Co. v. Bruch*, No. 87-1054, this term. A central issue raised by the petitioners in this case, whether the arbitrary and capricious standard of review is a legitimate standard of review when an ERISA fiduciary has a direct financial interest in the outcome of its dicisions, is also the central issue in *Bruch*. The delegation of authority to a self-interested party and judicial deference to that party's decisions raises obvious and serious Constitutional questions. Unfortunately, however the Constitutionality of the application of a deferential standard of review appears not to have been raised by the parties at any time in *Bruch*. Clearly, the narrowness of the parties' approach in *Bruch* may artificially constrain the Court's consideration of the problem of the financially self-interested fiduciary. A decision reached this term within the narrow framework presented by the parties in *Bruch* might, for example, require the Court to overrule itself when it eventually considers the Constitutional challenge.

What is the Constitutional challenge to the use of the arbitrary and capricious standard of review in reviewing decisions of self-interested fiduciaries? In brief, and for purposes of illustration only, it is this.

ERISA fiduciaries are creatures of statute. Under ERISA any person who exercises any discretionary authority or discretionary control respecting the management or administration of an employee benefit plan is, by definition, a fiduciary. 29 U.S.C. 1002(21)(A). This broad definition seems, at first, unqualified. However, subsequent provisions of ERISA mandate that a fiduciary shall not deal with the assets of a plan in his own interest or for his own account, or act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or receive any consideration for

his own personal account form a party dealing with the plan in a transaction involving plan assets. 29 U.S.C. § 1106(b). Curiously, however, ERISA's proscriptions against conflicts of interest have generally been ignored in determining whether a party is qualified to be an ERISA fiduciary.

One of the most important consequences of becoming a fiduciary is in the substantial deference Courts accord fiduciary decisions. Courts have generally interpreted ERISA as conferring broad discretionary authority upon ERISA fiduciaries to interpret the provisions of employee benefit plans and to grant or deny claims for benefits subject only to limited judicial scrutiny under the arbitrary and capricious standard of review.[3] Indeed, the only opportunity for a full review of a denied claim is by appeal to the fiduciary who is charged with providing a "full and fair review" under ERISA. Thus, it is clear the ERISA fiduciary is delegated a quasi-judicial authority. The question then becomes, how can the delegation of such authority be constitutional when a fiduciary has a financial interest in the decisions he is charged both with making initially and with "fully and fairly" reviewing? (In the instant case all claims authority including review authority rested with Metropolitan.)

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[3] Every Circuit Court of Appeals has at times applied the arbitrary and capricious standard of review to ERISA actions. *See Jestings v. New England Tel. and Tel. Co.*, 757 F.2d 8 (1st Cir. 1985); *Miles v. New York State Teamsters Conference Pension and Retirement Fund Employee Benefit Plan*, 698 F.2d 593 (2d Cir. 1983), *cert. denied*, 464 U.S. 829, 104 S.Ct. 105, 78 L.Ed.2d 108 (1983); *Edwards v. Wilkes-Barre Publishing Co. Pension Trust*, 757 F.2d 52 (3rd. Cir. 1985); *Lefebre v. Westinghouse Electric Corp.*, 747 F.2d 197 (4th Cir. 1984); *Offutt v. Prudential Ins. Co.*, 735 F.2d 948 (5th Cir. 1984); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109, 105 S.Ct. 786, 83 L.Ed.2d 780 (1985); *Sly v. P.R. Mallory & co.*, 712 F.2d 1209 (7th Cir. 1983); *In re Vorpahl*, 695 F.2d 318 (8th Cir. 1982); *Elser v. I.A.M. Nat'l Pension Fund*, 684 F.2d 648 (9th Cir. 1982), *cert. denied*, 464 U.S. 813, 104 S.Ct. 67, 78 L.Ed.2d 82 (1983); *Peckham v. Board of Trustees*, 653 F.2d 424 (10th Cir. 1981); *Sharron v. Amalgamted Ins. Agency Services*, 704 F.2d 562 (11th Cir. 1983); and *Stewart v. National Shopmen Pension Fund*, 730 F.2d 1552 (D.C. Cir.), *cert. denied*, 469 U.S. 834,

Thus, by statutory definition and judicial construction the ERISA fiduciary becomes the first and most important adjudicator in the chain of ERISA claims adjudication.[4] As the Sixth Circuit noted in *Blau v. Del Monte*, 748 F.2d 1348, 1352 (1984), "in this case, this Court, like the trial court, reviews another decisionmaker, the welfare benefit plan administrator."

This method of claims adjudication becomes Constitutionally questionable, however, when the initial decisionmaker becomes, in effect, the judge of his own case because of his direct financial interest in the outcome of his decision.

There are several obvious situations in which the decision-making process is tainted by the direct financial interest of the decisionmaker. Insurance companies such as Metropolitan in this case, which sell group, life, accident, health or disability insurance to company employees, while also making all benefit

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105 S.Ct. 127, 83 L.Ed.2d 68 (1984). There is a split among the Circuits only with respect to the appropriateness of a deferential standard of review when a fiduciary's interests conflict with those of a claimant. The formulation of the arbitrary and capricious standard of review varies greatly. Only two things are certain about it. It is always imprecise, and it always embodies some preference for the initial decision of the fiduciary over the claim of the person challenging the fiduciary's decision.

[4] Deciding eligibility for claims benefits and interpreting plan provisions is clearly an adjudicatory function rather than ministerial since the discretion of the claims fiduciary is very broad. With respect to claims, discretion it is generally limited only by the language of the plan which the fiduciary also has the discretion to interpret. Thus, the question of whether the functions of the self-interested fiduciary under ERISA are adjudicatory or ministerial doesn't seriously arise here as it did in *Keith Fulton & Sons, Inc. v. New England Teamsters and Trucking Industry Pension Fund, Inc.*, 762 F.2d 1137 (1st Cir. 1985), and *United Retail & Wholesale Emp. v. Yahn & McDonnell*, 787 F.2d 128 (3rd Cir. 1986) affirmed without opinion by an evenly divided court, 107 S.Ct. 2171 (1987).

claims decisions, and being obligated to pay claims from its own funds, are obviously self-interested fiduciaries. To the extent that it can reduce the money it pays out on claims, an insurer will maximize its profits, or in cases in which it has miscalculated the probable claims experience under its policy, limit its losses. The financial interest of an insurer is even more clearly at stake when, as here, the issue is the meaning of a contract provision which has an impact on the claims of large numbers of beneficiaries.

Employers such as Firestone Tire & Rubber Co. in *Bruch* who administer employee welfare or pension benefit plans which they must fund themselves according to the claims experience of the plan also have an obvious interest in the outcome of the benefit claims decisions they are charged with making.

Courts and litigants have been slow to come to grips with the problem of the self-interested fiduciary. Most Courts have applied the arbitrary and capricious standard of review in self-interested fiduciary cases without even addressing the propriety of applying that standard in such cases.[5]

For purposes of analytical purity it should be pointed out here that there are really two issues which often and sometimes necessarily become entwined. The first questions the validity of permitting a self-interested party even to be a fiduciary and the second questions the validity of applying a deferential standard of review to that fiduciary's decisions.

The Constitutional issue arises initially out of the delegation of decisionmaking and review authority to self-interested

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[5] *See e.g. Offutt v. Prudential Insurance Co. of America*, 735 F.2d 948 (5th Cir. 1984).

fiduciaries by ERISA[6] and becomes acute when Courts then defer to the decisions of self-interested fiduciaries by reviewing their decisions only to determine whether they are arbitrary and capricious.

In addition to any statutory delegation of decisionmaking authority under ERISA, the application of a deferential standard of review is also, in itself, a further delegation of decisionmaking latitude and, therefore, authority to the fiduciary whose decision is accorded deference. As we have noted, that fiduciary then becomes, in effect, the first and most critical judge in the chain of adjudication.[7] However, the delegation of such authority, whether explicit or *de facto*, to a self-interested fiduciary with a direct financial interest in the decisions it makes as a fiduciary denies to plan participants the impartial adjudication of claims guaranteed by the Constitution.

The rule *nemo judex in re sua* or the tenet that no man is to be a judge in his own cause, is a central tenet of the English common law from which our own law developed. In *Dr. Bonham's Case*, Lord Coke insisted that a court had the right to invalidate acts of Parliment which would permit a man to be the judge of

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[6] A fiduciary under ERISA is defined very broadly in terms of the functions performed in connection with any sort of welfare or pension plan. The definitional section creating fiduciaries, however, fails to distinguish between self-interested and disinterested parties. 29 U.S.C. § 1002(21)(A). Thus, read literally and in isolation, § 1002(21)(A) seems to permit even parties with a direct financial stake in the decisions they make possess fiduciary authority. Nor does 29 U.S.C. § 1133(2) prohibit self-interested parties from being responsible for providing denied claims a "full and fair review".

[7] *Blau v. Del Monte Corp.*, 728 F.2d at 1352 (in the context of reviewing a decision under ERISA the court noted, "in this case, this court like the trial court reviews another decisionmaker, the welfare plan administrator.")

his own cause.[8] This concern for adjudicatory fairness influenced the framers of our Constitution.[9]

A number of Supreme Court decisions have thoroughly examined the question of whether the due process clause permits adjudicatory or quasi-adjudicatory authority to be exercised by a party with a financial interest in the outcome of its decision. The first of these decisions was *Tumey v. Ohio*, 273 U.S. 510 (1929)

Tumey was a criminal case involving a defendent who was prosecuted for violating Ohio's prohibition laws. The defendent was found guilty by a judge who also served as the local mayor. The mayor was paid for his services as a judge solely from fines collected from those convictions. If no fines were collected there would be no payment.

After a lengthy review of both English and American common law the Court concluded that the Constitutional guarantee of due process mandated that adjudicatory authority be exercised by an impartial tribunal. *Id,* 535. The Court reversed the decision of the Supreme Court of Ohio upholding the payment from fines arrangement saying:

> It is finally argued that the evidence shows clearly that the defendent was guilty and that he was only fined $100, which was the minimum amount and, therefore, that he can not complain of a lack of due process, either in his conviction or in the amount of the judgment. The plea was not guilty and he was convicted. No matter what the evidence was against him, he had a right to have an impartial judge. He seasonably raised the objection and was en-

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[8] Redish and Marshall. Adjudicatory Independence and The Values of Procedural Due Process. 95 Yale Law Journal, 454, 480 (Ja. 1986).

[9] Id.

titled to halt the trial because of the disqualification of the judge, which existed both because of his direct precuniary interest in the outcome, and because of his official motive to convict and to graduate the fine to help the financial needs of the village. There were thus present at the outset both features of the disqualification. *Id.*

The Constitutional guarantee of an impartial tribunal was next invoked by the Supreme Court in *Ward v. Village of Monroeville* (409 U.S. 57 (1972)). *Ward* involved the conviction of the petitioner for two traffic offenses which resulted in a $50 fine for each offense. An Ohio statute authorized mayors to sit as judges in such cases, and the mayor of Monroeville had convicted the petitioner. This case was unlike *Tumey*, in that there was no direct connection between the amount of salary received by the judge-mayor and the fines received as a result of his convictions. Nevertheless, the revenues from such fines contributed substantially to town revenues. In fact, such fines constituted approximately half of Monroeville's total revenues in some years and a very substantial portion of its revenues in others. *Id,* 58.

The court held in *Monroeville* that even though the mayor had no direct pecuniary interest in the fine collection arrangement, the fact that the town for which he was the chief administrator did have a very substantial interest in the arrangement denied the impartial tribunal guaranteed by the due process clause to those who were convicted by the mayor in his capacity as judge. *Id,* 61-62.

Justice White dissented, contending that *Tumey v. Ohio* was distinguishable from *Monroeville* because the mayor-judge in the latter case had no direct financial stake in its outcome. The dissenting opinion, however, ignored the dual holding in *Tumey* which found the Constitutional guarantee of impartiality to be denied because of both the direct pecuniary interest of the judge *and* because of his official motive to "help the financial needs of the village." *Tumey v. Ohio*, 273 U.S. at 535.

Although Justice White wrote the dissenting opinion in *Monroeville*, the following year he authored the opinion of the Court in *Gibson v. Berryhill (411 U.S. 563 (1973))*.

In Gibson, the Alabama Optometric Association filed charges with the Alabama Board of Optometry (invested with statutory authority just as are ERISA fiduciaries) charging that approximately one half the optometrists in the state who worked for a corporation were, by virtue of their employment by the corporation, engaged in unprofessional conduct (411 U.S. 564 (1973)). The charges were filed with the Alabama Board of Optometry whose members were limited to independent practitioners of optometry with memberships in the Alabama Optometric Association and who thereby stood to gain at least indirectly by revocation of the licenses of those who worked as employees of the corporation employing a large number of the state's optometrists. Importantly, the Court, relying on the precedents of *Tumey* and *Ward* concluded that the law concerning disqualification because of interest applies to administrative as well as to more formal judicial adjudication. *Id* at 579. The Court thereby affirmed the decision of the District Court holding that because of the potential personal benefit the revocation of the licenses of the optometrists employed by the corporation would have for independent optometrists, including members of the Board, the members of the Board were thereby disqualified on constitutional grounds from hearing the charges filed against the employed optometrists. *Id*. at 578.

In neither *Gibson* nor *Ward* was the availability of *de novo* review sufficient to correct the Constitutional flaw in the tribunal of the first instance.

The Court most recently addressed the issue of judicial disqualification because of the existence of a pecuniary interest in *Aetna Life Ins. Co. v. Lavoie* (106 S.Ct. 1580 (1986)). In *Lavoie*, the Alabama Supreme Court upheld a punitive damage award against Aetna Life & Casualty Co. In a five to four deci-

sion, the Alabama Court held that the evidence demonstrated the insurer had in fact acted in bad faith. *Id.* at 1583.

It was later discovered that one of the justices in the majority had pending two actions for bad faith against insurance companies. The Supreme Court concluded that the justice's interest in the precedential value of the case he was deciding and in the "affirmance of the largest punitive damage award ever" gave him a direct, personal and substantial pecuniary interest in the case he was deciding and, therefore, required his disqualification. *Id.* at 1586. The Court expressly affirmed the Constitutional principle articulated in *Tumey*, *Ward*, and *Gibson*, that the Constitutional gaurantee of due process requires in both the administrative and judicial context that one's case be decided by a tribunal whose presumptive impartiality is not tainted by a direct pecuniary interest.[10]

In light of such forceful precedent, the routine application of the arbitrary and capricious standard of review to the decisions of self-interested fiduciaries seems surprising. It also seems blatently unfair from a rudinentary, common sense perspective. Indeed, the case for the due process challenge seems stronger in the ERISA context than it did even in *Ward* and *Gibson*. Under ERISA courts (with the single exception of the Third Circuit in *Bruch*) deny *de novo* review even when decisions of self-interested ERISA fiduciaries are challenged, while in *Ward* and *Gibson de novo* review was available. Thus, not only is there a

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[10] The court, however, was careful to note in *Lavoie* that it is not necessarily holding that a decision should be set aside where there is "the slightest pecuniary interest" on the part of a tribunal. Justice Berger's opinion suggested that there may some cases in which the pecuniary interest is so remote, trifling and so insignificant that disqualification would not be warranted. *Id*, at 1587 n. 3.

Certainly in most ERISA claims cases, however, the interest of a self-insured corporate administrator or an insurance company in denying benefits would be substantial enough for disqualification since in many cases such benefits can amount, over time, to hundreds of thousands, and with multiple claims, millions of dollars.

Constitutional taint in the initial statutory delegation of decisionmaking authority, that taint is compounded by the limitation on meaningful judicial review.

Examined in light of the precedent we have been discussing it seems obvious that an ERISA fiduciary's direct, financial self-interest in its claims decisions (and also naturally in the "full and fair review" of those decisions) deprives the claimant of an impartial tribunal and thereby of the due process of law guaranteed by the Constitution. The application of the deferential arbitrary and capricious standard of review to decisions which are already Constitutionally defective compounds the problem and creates a *de facto* presumption in favor of the self-interested fiduciary.

Is there a solution? The Third Circuit held in *United Retail & Wholesale Emp. v. Yahn & McDonnell* (787 F.2d 128 (3rd Cir. 1986) affirmed without opinion by an evenly divided Court, 107 S.Ct. 2171 (1987)), that a statute which explicitly presumed the correctness of trustees' decisions under the Multi-emloyer Pension Plan Amendments Act of 1980 was unconstitutional because the trustees who benefited from the presumption had a financial interest in the outcome of the decisions they would make as trustees.

In ERISA, however, there is no explicit statutory presumption of correctness. Nevertheless, the judicially imposed "arbitrary and capricious" standard of review has the effect of a presumption of correctness. In any of its varied articulations there remains an adjudicatory bias in favor of the position advanced by the fiduciary. The fiduciary always wins unless the claimant can meet the heavy burden of showing that the fiduciary's position is arbitrary and capricious. See *Allen v. United Mine Workers of America*, 726 F.2d. 352, 354 (7th Cir.) and *Teskey v. M.P. Mutual Products, Inc.*, 795 F.2d. 30, 32 (7th Cir. 1986).

In seeking a solution to the Constitutional difficulty presented by ERISA it is first necessary to ask if the broad

definitional section of ERISA which cloaks the self-interested and impartial alike in the mantle of fiduciaryhood must held unconstitutional? While there is an obvious statutory assumption that ERISA fiduciaries will be claims decisionmakers, there is latitude within ERISA to support judicial interpretations which read ERISA to prohibit persons or corporations with a direct financial stake in the outcome of the decisions they would presume to make as fiduciaries from acting as fiduciaries. While 29 U.S.C. 1002(21)(A) defines as a fiduciary any person exercising discretionary authority or responsibility with respect to plan administration, other provisions of ERISA require neutrality. 29 U.S.C. § 1106 prohibits a fiduciary from dealing with the assets of the plan in his own interest or for his own account (an insurance policy is a plan asset (see 29 U.S.C. § 1103(b)(1)). The same section also prevents a fiduciary from acting in any capacity in any transaction involving the plan on behalf of a party whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries (29 U.S.C. § 1106(b)(1)). A similar mandate is found in 29 U.S.C. § 1104 which requires a fiduciary to discharge his duties "solely in the interest of the participants and beneficiaries...". It is, however, contradictory to assume that a person can be a financially self-interested fiduciary and live up to the standards imposed by § 1106 and § 1104. It is probably not necessary to find any section of ERISA unconstitutional to resolve Constitutional dilemma presented by the self-interested fiduciary. The Court could save the statute by interpreting ERISA so that entities with a direct financial interest in the outcome of the decisions they are charged with making under ERISA are disqualified from serving as fiduciaries. It may be Constitutionally sufficient merely to hold that fiduciaries with a financial interest in the outcome of their decisions are to be treated as any ordinary private party in interest in a lawsuit and that any claimant challenging the decision of a self-interested party is entitled to a full trial in which the decision of the self-interested party is not to be given any weight at all. In any event, however, The Supreme Court will not be

able to examine adequately the question of what standard of review applies when the decisions of financially self-interested fiduciaries are challenged unless the issue of the constitutionality of delegating decisionmaking authority to self-interested fiduciaries is properly before it.

In the instant case the question of what standard of review properly applies is outcome determinative. Strict judicial neutrality in this case would have required the Court to analyze the insurance contract at issue under standard contract principles which in the First Circuit prevent the revision or extension of contract terms by judicial "reason" or "logic", but require that the terms of the contract be enforced according to the language in the document. *Triple-A Baseball Club v. Northeastern Baseball*, 832 F.2d. 214 (1st Cir. 1987). In the instant case, however, the contract contained, as the District Court admits, no mention of recoupment whatsoever. Rather Metropolitan's contract provides only for month by month offsets as did its contract in *Bush v. Metropolitan Life Ins. Co.*, 656 F.2d. 213 (6th Cir. 1981). (Subsequently Metropolitan amended its contract to provide for recoupment.)

ADDITIONAL REASONS FOR GRANTING THE WRIT

A writ of *certiorari* should also be granted in this case for the same reasons it was granted in *Firestone Tire & Rubber Co. c. Bruch*, No. 87-1054. There is obviously a split among the circuits. While in *Bruch* the Third Circuit explicitly rejected the arbitrary and capricious standard of review in self-interested fiduciary benefit cases, the First Circuit has upheld its use in the instant case, the Seventh Circuit has defended it in dicta in *Van Boxel v. Journal Company Employees Senior Trust*, 836 F.2d. 1048 (7th Cir. 1987) and the Fifth Circuit has applied it in *Offutt v. Prudential Ins. Co.*, 753 F.2d 948 (5th Cir. 1984). The conflict among circuits and, in fact, confusion, is destined to become worse until the Supreme Court fully considers how the Courts are to deal with challenges to the decisions of financially self-interested fiduciaries under ERISA.

Finally, the lower Court's conclusion that an insurer is entitled to claim an offset in direct response to the receipt of a Social Security award not withstanding the proscription against the alienation of Social Security payments by the Social Security Act, 42 U.S.C. § 407, is so directly contrary to the reasoning of this Court dealing with federal protection of benefit statutes in *Philpott v. Essex County Welfare Board*, 409 U.S. 413 (1973), *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979), and *McCarty v. McCarty*, 453 U.S. 210 (1981) as to warrant review by the Supreme Court. The lower Court's decision has the somewhat scandalous effect of making an insurance company the true beneficiary of a retroactive Social Security payment. It is the plaintiffs' position that such a diversion of federal tax dollars has not been countenanced by the Supreme Court and should not be countenanced by the lower courts.

CONCLUSION

For the reasons stated herein, the most important of which is to allow this Court to consider the full range of questions bearing on the appropriate standard of review in ERISA cases which involve challenges to the decisions of financially self-interested fiduciaries, this petition for a writ of *certiorari* should be granted.

Respectfully submitted,

Jon Holder, Esquire
Counsel of record for petitioners

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 87-1998

Gertrude M. Stuart, Et. Al.,
Plaintiffs, Appellants,

v.

Metropolitan Life Insurance Company,
Defendant, Appellee.

JUDGMENT

Entered: July 7, 1988

This cause came on to be heard on appeal from the United States Disrict Court for the District of Maine, and was argued by counsel.

Upon consideration whereof, it is now here ordered, adjudged and decreed as follows: The judgment of the district court is affirmed.

By the Court:
FRANCIS P. SCIGLIANO, CLERK
By: Daniel F. Loughry
Chief Deputy Clerk.

[cc: Messr. Holder and Ms. Mayer]

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 87-1998

Gertrude M. Stewart, Etc., Et. Al.,
Plaintiffs, Appellants,

v.

Metropolitan Life Insurance Company,
Defendant, Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MAINE

[Hon. Gene Carter, U.S. District Judge]

Before

Bownes, Breyer and Torruella,
Circuit Judges.

Jon Holder with whom Holder & Grover, P.A. was on brief for appellants.

Nancy Mayer with whom William J. Toppeta, Howard H. Dana, Jr., and Verrill & Dana were on brief for appellee.

July 7, 1988

Per Curiam: For the reasons set forth in the opinion of the District Court its judgment is affirmed.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

Civil No. 85-0318 P

Gertrude M. Stuart, Personal Representative of the Estate of William R. Stuart,

Plaintiff,

v.

Metropolitan Life Insurance Company,

Defendant.

Civil No. 85-0388 P

Fernand Danis,

Plaintiff,

v.

Metropolitan Life Insurance Company,

Defendant.

JUDGMENT

The Court having, by Order dated June 11, 1987, stricken Counts, I, V, VII, and VIII of the Amended Complaints in these matters, and Counsel for the Plaintiffs having voluntarily dismissed Count IV,

Now, therefore in accordance with the Memorandum of Decision and Order of Carter, J., dated July 14, 1987, JUDGMENT is hereby entered for the defendant, Metropolitan Life Insurance Company, and against the Plaintiffs, Gertrude M. Stuart, Personal Representative of the Estate of William R. Stuart and Fernand Danis, on Counts II, III, and VI and the within actions are dismissed on the merits.

Dated at Portland, Maine this 16th day of July, 1987.

A True Copy
ATTEST: William S. Brownell, Clerk
By: Susan Whitter
DeputyClerk
/s/ William S. Brownell, Clerk
United States District Court

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

Civil No. 85-0318-P

William Stuart,
Plaintiff,

v.

Metropolitan Life Insurance Company,
Defendant.

Civil No. 85-0388-P
(Consolidated)

Fernand Danis,
Plaintiff,

v.

Metropolitan Life Insurance Company,
Defendant.

CARTER, District Judge

MEMORANDUM OF DECISION AND ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Plaintiffs Stuart[1] and Danis brought suit to challenge the recoupment of benefits by Defendant Metropolitan Life Insurance Company (Metropolitan) in an amount equal to retroactive lump-sum Social Security payments received by each Plaintiff. Jurisdiction is invoked pursuant to 29 U.S.C. § 1132 (1982), 28 U.S.C. § 1331 (1982), and 28 U.S.C. § 1332 (1982).

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[1] William Stuart, Jr., the named Plaintiff in Civil No. 85-0318-P, died on November 13, 1986. Without objection, the Court substituted Gertrude M. Stuart, as surviving spouse and personal representative of Stuart's estate, to be the named plaintiff. Any reference in this opinion to "Plaintiff Stuart" is to William Stuart, Jr.

Because the two cases involve nearly identical questions of fact and identical questions of law, the cases have been consolidated for all pretrial purposes.

The Plaintiffs' Amended Complaints[2] set forth eight counts; of the eight, only three now remain.[3] Count II alleges that Defendant breached its duties as an ERISA fiduciary in violation of 29 U.S.C. §§ 1022, 1104 (1982). Count III alleges that Defendant's recoupment breached the anti-assignment provision of the Social Security Act, 42 U.S.C. § 407 (Supp. III 1985). Finally, Count VI alleges a violation of New York Insurance Law § 3212.

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[2] References to specific counts and to the "Amended Complaint" are to the Amended Complaints dated September 16, 1986. (Those Amended Complaints were received and filed by the Court on March 11, 1987, the date on which the Magistrate granted Plaintiffs leave to amend. Magistrate's Memorandum and Recommended Decision at 3.) The Court notes, in order to avoid any potential confusion, that it denied Plaintiffs' second request to amend their complaints. Memorandum of Decision and Order Denying Plaintiffs' Motion to Amend Complaint and Granting Defendant's Motion for Protective Order and Extension of Time (June 11, 1987) [hereinafter cited as Memorandum of Decision and Order].

[3] The counts previously disposed of are as follows: Count IV (breach of Maine insurance statutes) was voluntarily dismissed by the Plaintiffs at oral argument before the Magistrate. Magistrate's Memorandum and Recommended Decision at 3. Counts I (common-law breach of contract), V (fraud and wilful failure to deal in good faith), VII (knowing and wilful violation of fiduciary duties), and VIII (conversion) were ordered stricken from the pleadings in light of two recent Supreme Court decisions: *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. 1549 (1987), and *Metropolitan Life Insurance Co. v. Taylor*, 107 S.Ct. 1542 (1987). *Dedeaux* and *Taylor* establish that the Employee Retirement Income Security Act (ERISA) preempts state common-law causes of action alleging improper processing for claims under an ERISA-regulated benefit plan. Accordingly, Plaintiffs conceded that Counts I, V, VII, and VIII did not allege valid causes of action, and the Court ordered those counts stricken from the pleadings. Memorandum of Decision and Order at 6.

Now pending before the Court are the parties' cross-motions for summary judgment on Counts II, III and VI. Both parties have submitted memoranda, as well as Statements of Undisputed Material Facts as required by Local Rule 19(b). The Court also has the benefit of the Magistrate's Memorandum and Recommended Decision. Having considered *de novo* all of the materials properly before it, *Jacobsen v. Mintz, Levin, Cohn, Ferris, Glovsky & Popeo, P.C.*, 594 F.Supp. 583 (D. Me. 1984), the Court concludes that Defendant's motion for summary judgment should be granted, and Plaintiffs' motion for summary judgment denied.

I. Facts

Plaintiffs Stuart and Danis both worked as hourly employees of the General Electric Company (GE) at the GE plant in South Portland, Maine. Stuart was employed as an International Association of Machinists and Aerospace Workers-AFL-CIO union member and Danis was a nonunion employee.

In 1970, as part of the collective bargaining process, GE and the unions representing its employees negotiated a Long Term Disability Plan (the Plan). As a result of that process, GE obtained Group Insurance Policy Number 23126-G (the Policy) from Metropolitan. The Policy, which provided long-term disability insurance, incorporated the Plan by reference.[4] Participation in the Plan was voluntary, and employees paid the entire premium. GE made the Plan available on the same terms to nonunion employees.

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[4] The Plaintiffs contend that there is a dispute over Metropolitan's role in drafting the language of the Plan. The Magistrate rejected this contention based on direct statements in the Affidavits of Stephen Tsorvas and David F. Walsh that GE and the unions negotiated the Plan's terms and conditions. Magistrate's Memorandum and Recommended Decision at 1 n. 1. The Court adopts the Magistrate's finding that Metropolitan was not a party to and did not participate in the negotiations between GE and the unions.

Both Plaintiffs purchased coverage under the Plan and both became disabled. The relevant language of the Plan provided that:

> Benefits will be paid monthly and will be one twenty-fourth of your normal straight-time annual earnings reduced by . . . (2) any primary Social Security benefits. . . . If the benefits referred to in (2) . . . would have been payable to you upon timely application, you will be considered as receiving such benefits. However, in no event, will the reductions referred to in . . . (2) be used to reduce the monthly benefit otherwise payable to less than $50 a month.

Plaintiff Stuart's Deposition, Exhibit 1-D, at 39; Appendix to Plaintiff Danis' Motion for Summary Judgment, Exhibit 1-F, at 2.

When Stuart and Danis applied for disability benefits under the Plan, GE required each to sign a Reimbursement Agreement. The first paragraph of the Agreement required each Plaintiff to certify that he had made timely application for Social Security benefits. The Agreement then provided that Metropolitan would not deduct estimated Social Security benefits from Plaintiffs' monthly benefits under the Plan if Plaintiffs agreed to reimburse Metropolitan in full upon receipt of any retroactive Social Security payment. The Agreement also authorized Metropolitan to enforce this right to reimbursement, if necessary, by withholding or reducing future long-term disability benefits. Plaintiffs Stuart's Deposition, Exhibit 3; Appendix to Plaintiff Danis' Motion for Summary Judgment, Exhibit 3.

Both Plaintiffs applied for and were denied Social Security benefits. Each Plaintiff then signed the Reimbursement Agreement and immediately began receiving benefits under the Plan. The decision denying Social Security benefits was ultimately overturned, and each Plaintiff received a retroactive lump-sum disability payment. Metropolitan requested reimbursement,

and when Plaintiffs failed to comply, Metropolitan began to recoup those amounts by withholding monthly benefits under the Plan. In the case of each Plaintiff, the withholding resulted in the loss of all monthly benefits under the Plan.

Plaintiffs then filed suit to challenge Metropolitan's recoupment.

II. Count II: Breach of ERISA Fiduciary Duties

In Court II, Plaintiffs allege that Metropolitan breached the fiduciary duties imposed by 29 U.S.C. § 1104. In particular, Plaintiffs claim that Metropolitan violated 29 U.S.C. § 1022 by failing to explain in the plan summary the provisions now in dispute; Plaintiffs further claim that Metropolitan breached its fiduciary duties by failing to provide benefits as required by the Plan.

The Court rejects Plaintiffs' contention that Metropolitn violated 29 U.S.C. § 1022. The Magistrate correctly recognized that section 1022 — which does require that a "summary plan description" (SPD) of any employee benefit plan be furnished to participants and beneficiaries — imposes obligations only on the plan administrator. *See* 29 U.S.C. §§ 1021, 1022, 1024(b)(1) (1982).[3] As defined by ERISA, the term "administrator" means "the person specifically so designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A)(i). The Plan governing Plaintiffs' benefits specifically provides that GE, not Metropolitan, is the Plan Administrator. Accordingly, section 1022 imposes obligations on GE, and Metropolitan cannot be found to have violated those mandates.

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[3] The summary plan description "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1). Section 1022 also specifies certain information that must be contained in the SPD, including an explanation of the procedures to be followed in presenting claims and the remedies available if claims are denied. 29 U.S.C. § 1022(b).

The Court also finds, as did the Magistrate, that summary judgment should be granted for Metropolitan on Plaintiffs' claim that Metropolitan's recoupment of benefits violated its fiduciary duties. The Court, however, reaches this result for a different reason.

The Magistrate cited caselaw for the proposition that exhaustion of administrative remedies is a prerequisite to judicial determination of a claim for breach of ERISA fiduciary obligations. *See Denton v. First Nat'l Bank,* 765 F.2d 1295, 1300-01 (5th Cir. 1985); *Amato v. Bernard,* 618 F.2d 559, 566-68 (9th Cir. 1980); *Worowsic v. Nashua Corp.,* 612 F.Supp. 310, 314 (D.N.H. 1985). The Magistrate then concluded that "[i]t is undisputed that the plaintiffs here did not exhaust their administrative remedies." Magistrate's Memorandum and Recommended Decision at 9 (footnote omitted).

If it was not clear on the record before the Magistrate, it is clear now that Plaintiffs do dispute the issue of exhaustion. Plaintiff's Revised Memorandum of Law in Support of their Motion For Summary Judgment, at 33-37. Plaintiffs cite correspondence between Metropolitan officials and Plaintiffs' counsel to support their claim that they followed the appeals

process established by Metropolitan.[6] Appendix to Plaintiff Danis' Motion for Summary Judgment, Exhibit 4 (Letter of May 30, 1984 from Delores Randazzo, Claims Supervisor, to Plaintiffs' counsel); Appendix to Plaintiffs' Revised Memorandum of Law in Support of their Motion for Summary Judgment, at 34-35 (Letter of June 12, 1984; same). That correspondence is sufficient to raise a question in the Court's view as to whether Plaintiffs exhausted their administrative remedies.

After reviewing the record as a whole, however, the Court concludes that the question of exhaustion is immaterial, because Plaintiffs are not entitled to relief based on the merits of their claim. An action brought pursuant to 29 U.S.C. § 1132(a)(1)(B) (1982)[7] for benefits due under a pension plan requires the court

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[6] Defendant has suggested that Stuart, a union member seeking benefits under an ERISA-regulated plan adopted as part of a collective bargaining agreement, was required first to employ the grievance procedure under that agreement. The Court notes some authority suggesting that union members may satisfy the exhaustion requirement by an appeals process distinct from the grievance procedure. *See Wolf v. National Shopmen Pension Fund,* 728 F.2d 182 (3d Cir. 1984) (union remedies exhausted through appeal to Pension Fund); *Amato v. Bernard,* 618 F.2d at 568 (primary purpose of exhaustion requirement is to give pension plan fiduciaries full opportunity to interpret the plan). Because the Court finds exhaustion to be immaterial to the ultimate resolution of this claim, the Court need not, and does not, determine whether Stuart's failure to pursue his claim through the union's grievance process precludes judicial review. Rather, the Court assumes, without deciding, for the purposes of this summary judgment motion, that the correspondence on behalf of both Plaintiffs challenging Metropolitan's recoupment exhausted the remedies available to object to Metropolitan's action.

[7] Defendant contends that Plaintiffs' Count II seeks relief pursuant to 29 U.S.C. § 1132(a)(2), and that relief under that section is available only to the Plan. *See* 29 U.S.C. § 1109 (1982); *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. 134 (1985). The Court, however, has determined that the claim is for relief pursuant to 29 U.S.C. § 1132(a)(1)(B). The discussion in the text assumes that determination.

to review the plan administrator's determination under an "arbitrary and capricious" standard. This standard has been applied by every federal circuit court of appeals.[8] Application of the "arbitrary and capricious" standard involves a two-step process: "First, the court must determine the correct interpretation of the Plan's provisions. Second, the court must determine whether the Plan administrators acted arbitrarily or capriciously in light of the interpretation they gave the Plan in the particular instance." *Denton v. First Nat'l Bank,* 765 F.2d 1295, 1304 (5th Cir. 1985).[9]

Initially, then, the Court must examine the language of the Plan and of the SPD[10] to determine whether the recoupment

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[8] *See Jestings v. New England Tel. and Tel. Co., 757 F.2d 8 (1st Cir. 1985); Miles v. New York State Teamsters Conference Pension and Retirement Fund Employee Benefit Plan,* 698 F.2d 593 (2d Cir. 1983); *cert. denied,* 464 U.S. 829 (1983); *Edwards v. Wilkes-Barre Publishing Co. Pension Trust,* 757 F.2d 53 (3d Cir. 1985); *LeFebre v. Westinghouse Electric Corp.,* 747 F.2d 197 (4th Cir. 1984); *Offutt v. Prudential Ins. Co.,* 735 F.2d 948 (5th Cir. 1984); *Moore v. Reynolds Metals Co. Retirement Program,* 740 F.2d 454 (6th Cir. 1984), *cert. denied,* 469 U.S. 1109 (1985); *Sly v. P.R. Mallory & Co.,* 712 F.2d 1209 (7th Cir. 1983); *In re Vorpahl,* 695 F.2d 318 (8th Cir. 1982); *Elser v. I.A.M. Nat'l Pension Fund,* 684 F.2d 648 (9th Cir. 1982), *cert. denied,* 464 U.S. 813 (1983); *Peckham v. Board of Trustees,* 653 F.2d 424 (10th Cir. 1981); *Sharron v. Amalgamated Ins. Agency Services,* 704 F.2d 562 (11th Cir. 1983); and *Steward v. National Shopmen Pension Fund,* 730 F.2d 1552 (D.C. Cir.), *cert. denied,* 469 U.S. 834 (1984).

[9] Although the proposition cited is articulated in terms of the action of a plan administrator, the context makes clear that it is the action of the party charged with interpreting the Plan that is significant. Thus, the rule is no less valid in the present case because Metropolitan's action, rather than the action of the plan administrator (GE) is under scrutiny.

[10] The language of the summary plan description is binding, even though not technically a part of the contract. *See Bachelder v. Communications Satellite Corp.,* 657 F.Supp. 423 (D. Me. 1987).

was proper under those instruments. As with any contract, the Court must interpret the unambiguous language of the written document according to its plain and commonly accepted meaning. *Brackett v. Middlesex Ins. Co.*, 486 A.2d 1188, 1190 (Me. 1985). *See also Restatement (Second) of Contracts* § 202 (1981).

The plain and umambiguous language of the Plan, set out above, provides that monthly benefits under the Plan will be reduced by any Social Security benefits. The SPD furnished to each Plaintiff also provided that Social Security benefits would reduce the amount of monthly benefits under the Plan.[11]

Plaintiffs argue, however, that the relevant language says nothing about reducing Plan benefits upon the payment of *retroactive* Social Security payments such as the Plaintiffs in this case received. Plaintiffs argue further that the documents specifically guarantee "that a diabled insured will receive a continuing *monthly* income that will not fall below 50% of his pre-disability monthly income in combination with monthly income from certain other sources, such as Social Security" and that "a literal reading of the SPD would obligate Metropolitan to pay [a disabled insured] the amount he was initially entitled to while being denied Social Security payments without any subsequent

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[11] Plaintiff Stuart's Deposition, Exhibit 1-E, at 32 ("[t]he monthly LTD [long-term disability] benefit is reduced by monthly income from . . . Primary Social Security"); Appendix to Plaintiff Danis' Motion for Summary Judgment, Exhibit 1-G ("You receive 50% of your monthly pay from the LTD Plan in combination with other disability benefits subject to a minimum benefit of $50 per month. Your monthly LTD benefit depends upon the monthly income you're entitled to from Primary Social Security."). Although the language in the SPD furnished to Danis was not as clear as that in the SPD furnished to Stuart, the Court is satisfied that the language in both SPD's plainly provides for a reduction of Plan benefits upon the receipt of Social Security benefits. That meaning is also supported by the same example in each SPD describing Plan benefits that will be paid to provide 50% of annual pay "if [the] disability continues and [the] disability income from other sources such as Primary Social Security . . . [doesn't] total [50% of pay]. . . .

reductions for any reason, even to reflect contemporaneous offsets." Plaintiffs' Revised Memorandum of Law, at 20.

The Court finds Plaintiffs' argument to be without merit. The fact that the word "retroactive" is not used in the Plan or SPD language does not eliminate the fact that the clear language of those documents anticipated reductions in Plan benefits upon the receipt of Social Security benefits. A disabled insured would be required to accept such a reduction upon the immediate payment of Social Security benefits; it would be illogical to construe the contract language to mean that, because Social Security payments were delayed and then paid in a lump sum, the insured would be entitled to full Plan benefits and the Social Security payment. Plaintiffs' focus on an entitlement to a *monthly* income is similarly misplaced. Even with reductions for Social Security payments, a disabled insured would continue to receive a monthly payment of $50 under the Plan — unless, as in the case of these Plaintiffs, the insured had received benefits in an amount greater than that to which he was entitled. Nothing in the Plan or SPD prohibits — and the Reimbursement Agreement expressly allows — recoupment for payment of Plan benefits that becomes an overpayment upon the insured's receipt of retroactive Social Security benefits.

The Court is not without sympathy for Plaintiffs' situation. In particular, the Court is disturbed by Metropolitan's practice of presenting a Reimbursement Agreement for the disabled insured's signature at a time when the insured is most vulnerable. It seems to the Court that the language of the Agreement, which most clearly explains how receipt of Social Security benefits will affect the amount of income received under the Plan, could easily be included in the language of the Plan and SPD.[12] Never-

[12] Allowing itself for a moment to venture into the field of psychology, the Court suggests that complete and accurate disclosure of the effect of receiving retroactive Social Security benefits (or benefits from other sources) would go far to ensure contented subscribers. Simple reflection on human nature would indicate that it is the *sense* of having taken away with the one hand what is given by the other that creates resentment and disappointment in the insured. It is beyond the power of the Court's imagination to think that detailed disclosure would deter employees from signing up for the Plan.

theless, the Court cannot say that Metropolitan's recoupment of benefits paid violated the plain language of the contract. At least one other court has upheld recoupment under identical contract language. *Henning v. Metropolitan Life Ins. Co.*, 546 F.Supp. 442 (M.D. Pa. 1982) (*granting summary under New York law for defendant-insurance company*). *See also Poisson v. Allstate Life Ins. Co.*, 640 F.Supp. 147 (D. Me. 1986) (private insurer entitled to recoup benefits paid under disability plan that was integrated with receipt of government benefits when private beneficiary received lump-sum retroactive Social Security benefits) *Barklage v. Metropolitan Life Ins. Co.*, 614 F.Supp. 51 (W.D. Mo. 1985) (language in Plan and Reimbursement Agreement substantially similar to language in this case entitled defendant to reduce amount of monthly payments to recoup "advances" paid while Social Security claim was pending; summary judgment for defendant).[13]

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[13] The Court is aware of a Sixth Circuit case that arguably supports Plaintiffs' position. *Bush v. Metropolitan Life Ins. Co.*, 656 F.2d 231 (6th Cir. 1981). *Bush*, however, required the court to interpret contract language drafted by the insurance company providing for recoupment "[i]f it is determined that any benefits paid to an Employee under the Group Policy *should not have been paid or should have been paid in a lesser amount. . . .*" *Id.* at 232 (emphasis added). The court determined that language to be ambiguous and, construing the ambiguity against the drafter (Metropolitan), adopted Plaintiffs' interpretation that recoupment was permitted only when the insurance company erroneously overpaid according to conditions manifest at the time of the payment. The court held that the lump-sum retroactive payment of Social Security benefits could not be offset against future monthly benefits, but only against the monthly insurance benefit due for the month in which the lump sum was received.

The present case is distinguishable from *Bush* in two important respects. First, the language in the Plan and SPD was the product of negotiations between GE and the unions. *See supra* note 4. The language was not drafted by Metropolitan, so the principle of construing ambiguity against the drafter does not affect Metropolitan. Second, the language determined to be ambiguous in *Bush* was not included in the contracts of the Plaintiffs in this case. Thus, the Court need only interpret the unambiguous, plain language of the document, as it has done in the text.

III. Count III: Breach of Anti-Assignment Provision

In Count III, Plaintiffs allege that Metropolitan's withholding of benefits violates 42 U.S.C. § 407, which prohibits the transfer or assignment of Social Security benefits.[14] The Magistrate's Recommended Decision suggests that this Court's prior decision in *Poisson v. Allstate Life Insurance Co.*, 640 F.Supp. 147 (D. Me. 1986), is fully dispositive of the issues Plaintiffs raise under this Court. The Court agrees.

Poisson held that an integrated benefits plan (*i.e.*, a disability plan that provides variable benefits depending upon the amount of benefits received from other programs) does not violate section 407. As explained by the Court, "[t]he fact that Plaintiff ultimately received Social Security benefits for months past rather than present does not change the nature of the contract. [The insurance company] sought return of an alleged overpayment, not a right to Plaintiff's Social Security benefits as such." *Id.* at 149.

The Court is not persuaded by Plaintiffs' attempt to characterize the payment of benefits under an "integrated plan" as a transfer of Plaintiffs' rights to future Social Security benefits. Any recoupment for amounts not reimbursed is not a transfer, but payment for a debt owing to the insurer as agreed upon by the parties. The Court is also not persuaded by Plaintiffs' reliance on *Philpott v. Essex County Welfare Board*, 409 U.S. 413 (1973), and *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979). The Court maintains, as set out in *Poisson*, 640 F.Supp. at 149, that those cases are distinguishable.

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[14] Section 407(a) provides as follows:

> The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

42 U.S.C. § 407(a) (Supp. III 1985).

The court rejects Plaintiffs' invitation to reconsider its decision in *Poisson*. *Poisson* is fully dispositive of the issues in Count III. Summary judgment shall enter for Defendant Metropolitan and be denied to Plaintiffs.

IV. Count VI: Violation of New York Insurance Laws

Plaintiffs allege in Count VI that Metropolitan's withholding of benefits violates a New York[15] statute which provides: "No money or other benefits payable or allowable under any policy of insurance against any disability . . . shall be liable to execution for the purpose of satisfying any debt or liability of the insured. . . ." New York Insurance Law § 3212(c)(1). "Execution is defined to include "execution by garnishee process and every action, proceeding or process whereby assets of a debtor may be subjected to the claims of creditors." New York Insurance Law § 3212(a)(4).

Metropolitan argues in its Memorandum in Support of the Magistrate's Recommended Decision (June 22, 1987) that Plaintiffs' claim in Count VI is preempted by ERISA. Plaintiffs contend that section 3212(c)(1) is a law that "regulates insurance," and is therefore "saved" from preemption under section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).[16] *See*

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[15] The parties agree that, to the extent state law applied, New York law governs. Magistrate's Memorandum and Recommended Decision, at 3.

[16] Section 514(a) of ERISA provides that the statute shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a). A savings clause, however, provides that, with one exception, "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A). The exception, often referred to as the "deemer clause," provides:

> Neither an employee benefit plan . . ., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . .

29 U.S.C. § 1144(b)(2)(B).

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

The standards by which a court must determine whether a state statute "regulates insurance" are anything but clear. Although the Supreme Court provided some guidance in *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. at 738-47, and in *Dedeaux,* 107 S.Ct. at 1554-57,[17] the determination requires a new analysis for each statute invoked. The chore is especially difficult when, as here, a statute of another jurisdiction is involved, and there is a dearth of case law shedding light on the function of a particular provision in an overall statutory scheme. Given the uncertainty associated with the preemption question, the Court chooses to bypass that issue and address what is, in this case, the clearer and ultimately dispositive question of statutory interpretation.

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[17] The Supreme Court has looked at three factors to determine whether a state statute falls under the regulation-of-insurance savings clause. First, the Court examines, under a "common-sense view" of the word, whether the statute "regulates" insurance. The Court has explained that "in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry." *Dedeaux,* 107 S.Ct. at 1554. Second, the Court looks at criteria that have been used to interpret the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1021 (1982 & Supp. II 1984). Those criteria are:

> "*[F]irst,* whether the practice has the effect of transferring or spreading a policyholder's risk; *second,* whether the practice is an is an integral part of the policy relationship between the insurer and the insured; and *third,* whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982) (emphasis in original).

107 S.Ct. at 1553-54. Finally, the Court looks at "the role of the savings clause in ERISA as a whole." *Id.* at 1555. The Court has stated that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 1556-57.

Even if Plaintiffs were to prevail on their argument that section 3212 is not preempted by ERISA, they would not succeed on the merits of their claim. The Magistrate's Recommended Decision suggests, and the Court agrees, that New York Insurance Law section 3212(c)(1) proscribes only "execution" upon disability benefits; that section does not apply to an insurer's practice of recovering overpayments by withholding future payments. The Court agrees with the Magistrate that the definition of "execution" in section 3212(a)(4) anticipates some type of legal action taken to satisfy a debt or liability of an insured, and does not extend to a "self-help" situation where an insurer offsets benefits to recoup a prior overpayment. The only two New York cases cited that interpret the statute support such an interpretation. *Cohen v. Travelers Ins. Co.*, 275 A.D. 887, 90 N.Y.S.2d 719 (4th Dept. 1949); *Wilkes v. Equitable Life Assurance Soc'y*, 289 N.Y. 63, 43 N.E.2d 812 (1942).[18]

Plaintiffs urge the Court to interpret the word "execution" broadly to include *any* type of action that subjects the insured's benefits to creditors. If the Court were to adopt such a broad

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[18] In *Cohen*, the trial court had found that a defendant-insurer was entitled to recover prior overpayments and to compel payment of erroneously waived premiums; the trial court *ordered* that the life insurance policy lapse unless the insured paid the judgment within thirty-one days. The Appellate Division, citing New York Insurance Law section 166 (the former version of section 3212), ruled that the order must be stricken. In addition to the fact that a court order was involved, the dispute in *Cohen* was that of life insurance beneficiaries — not of the insured. Beneficiaries are treated differently than insureds under the statute. *See* New York Insurance Law § 3212(b).

Wilkes also involved a judgment by the trial court for an insured and an *order* for a setoff of future benefits. The New York Court of Appeals, also citing former section 166, held that judicial enforcement of the judgment out of disability benefits scheduled to become due was improper.

Unlike *Cohen* and Wilkes, the present case involves no prior judgment or court order subjecting Plaintiffs' disability benefits to Metropolitan's claim.

interpretation, then an insurer would have no means to recoup benefits even after a legal determination that the insured had indeed received an overpayment. The drafters surely did not intend such a result. The Court takes no position on whether specific ERISA provisions or other provisions of the New York Insurance Law regulate an insurer's entitlement to resort to "self-help" by offsetting benefits; the Court determines only that section 3212(c)(1) does *not* cover that situation.

Plaintiffs do not dispute the fact that Metropolitan's action in this case did not constitute "execution" in the sense of a legal proceeding, as defined in New York Insurance Law section 3212(a)(4). Plaintiffs' only argument has been that the definition should be interpreted expansively to include the "self-help" recoupment that occurred here. Because the Court has determined as a matter of law that section 3212 does not apply to the undisputed facts of this case, Defendant's motion for summary judgment must be granted (and Plaintiffs' motion deneid) on Count VI.

ORDER

In accordance with the foregoing, it is hereby *ORDERED* that

1. Defendant's motion for summary judgment on Counts II, III and VI be, and is hereby, *GRANTED;* and

2. Plaintiffs' motions for summary judgment on Counts II, III, and VI be, and is hereby, DENIED.

/s/ GENE CARTER
United States District Judge

Dated at Portland, Maine this 14th day of July 1987.

A TRUE COPY
ATTEST: William S. Brownell, Clerk

By/s/ Susan Whitter
Deputy Clerk

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

Civil Action Docket No. 85-0318 P, 85-0388 P

Gertrude M. Stuart,
as Personal Representative of the Estate of
William Stuart,
and
Fernand Danis,
Plaintiffs,

v.

Metropolitan Life Insurance Company,
and
General Electric Company,
Defendants.

Plaintiffs' Revised memorandum of Law in Support of Their Motion for Summary Judgment

I.

BACKGROUND

The Plaintiffs in this action formally worked for General Electric Company at its plant in South Portland, Maine. Both men became disabled and both received long-term disablility (LTD) insurance benefits under a Metropolitan Insurance policy which incorporated a General Electric long-term disability benefits plan. The insurance, however, was purchased entirely at the election of General Electric employees and entirely paid for by them.

The central promise of the insurance plan is that a disabled employee will receive a continuous post-disability *monthly* income equal to 50% of his monthly pre-disability pay. There is no mention in either the plan or the summary plan description that the receipt of a lump sum Social Security payment can

result in "indebtedness" to Metropolitan and in the complete loss of monthly LTD payments. (That is this case in a nutshell — except that nothing involving lots of money is so simple.) The *receipt* of certain other monthly income such as monthly Social Security benefits allows Metropolitan to reduce the monthly benefit it pays. In the example used in the summary plan descriptions (SPDs) covering the Plaintiffs, an employee whose pre-disability income is $1,000.00 per month, is guaranteed that his monthly post-disability income combined with Social Security benefits (and certain other benefits) will be $500.00 per month.[1] thus, if Social Security provides $400.00 a month, Metropolitan is obligated to pay only $100.00 per month. But, if Social Security (or other sources of offsettable benefits such as workers compensation) are paying nothing, then Metropolitan is obligated to pay the full $500.00 per month.

At the time both Stuart and Danis began receiving LTD insurance payments, the Social Security Administration denied their applications for Social Security benefits. Metropolitan, therefore, began paying the full 50% of the Plaintiffs' benefits. Subsequently, however, both Plaintiffs were awarded Social Security Benefits and received a lump sum retroactive payment to the time the Social Security Administration determined to be the beginning of their disability. Metropolitan then not only reduced its regular monthly payment but, claimed that the retroactive benefit awards *created* an "overpayment" and entitled Metropolitan, therefore, to take money back from Stuart and Danis. Danis was required to pay back $4,442.35 (Danis appendix exhibit 1; answer to interrogatory number 8) while Metropolitan demanded $12,941.22 from Stuart (Stuart appendix exhibit 1; answer to interrogatory number 8).

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[1] See "example" section of SPD's at exhibit 1-E and 1-G. 1-E is the SPD relevant to Stuart's claim while 1-G was in effect when Danis became disabled. (The Plaintiffs' suits were filed separately and a separate appendix has been submitted for each. To avoid confusion, however, the exhibit numbers for plan documents are the same in each appendix.)

At the time it claimed an "overpayment" and before the Plaintiffs even had a chance to request a review, Metropolitan terminated all benefits, offering to reinstate them upon payment of the amount it demanded.

Both Plaintiffs immediately protested Metropolitan's decision to terminate their benefits. When Metropolitan refused to reinstate their benefits, the Plaintiffs brought suit.

The real issue is whether under its contract Metropolitan may take back (i.e., treat as a contingent loan against Social Security awards) some of the money it had to pay during the months that Social Security benefits were being denied to their insureds. Metropolitan claims that it can. However, in its response to Danis' statement of material facts (dated March 13, 1986); "Metropolitan admits that the plan and policy do not contain language specifically authorizing the recovery of overpayments. *It is assumed.*" Paragraph III(5). (Emphasis added).[2]

The Magistrate issued a recommended decision which, in effect, proposed the denial of most of the Plaintiffs claims on procedural grounds. The Plaintiffs filed a timely objection.

In the meantime, however, the U.S. Supreme Court issued decisions in *Pilot Life Insurance Company v. Dedeaux*, 107 S.Ct. 1549 (1987) and *Metropolitan Life Insurance Company v. Taylor*, 107 S.Ct. 1542 (1987) which have a dispositive impact on certain of the Plaintiffs' counts. In light of these decisions the Court has ordered the parties to rebrief their motions for summary judgment and to address also in the new memoranda those of the Magistrate's recommendations which remain relevant.

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[2] It is apparent not only from the legislative history of ERISA, but from its specific mandates, that plan terms, especially terms relating to the loss of benefits, must be clearly presented. The termination of all benefits cannot be based on an unspoken assumption. 29 U.S.C. 1022: 29 CFR 2520. 102-1-102-3. See also, *Blau v. Del Monte Corp.* 748 F.2d. 1348, 1355 (9th Cir. 1985).

In this memoranda we continue to rely on the Plaintiffs' initial statements of material facts, their replies to the Defendant's statements of material facts, and the appendix submitted on behalf of each Plaintiff.

II.

THE IMPACT OF *PILOT LIFE INSURANCE COMPANY V. DEDEAUX* 107 S.Ct. 1549 (1987) AND *METROPOLITAN LIFE INSURANCE COMPANY V. TAYLOR* 107 S.Ct. 1542 (1987).

Pilot Life Insurance Company v. Dedeaux, supra, held (in Justice O'Connors own words) that "state *common law* causes of action asserting improper processing of a claim for benefits under an employee benefit plan regulated by the Employee Retirement Income Security Act (ERISA) . . . are pre-empted by the act." (Emphasis added.) *Metropolitan Life Insurance Company v. Taylor*, at 1544.

Although there is a great deal that is not clear in Justice O'Connor's companion opinions, it is clear that those claims which were based on state common law of general application, are preempted by ERISA. Accordingly, the Plaintiffs' have moved to amend their complaint, essentially for the purpose of conforming it to the Supreme Court's recent decisions. Secondarily, the Plaintiffs seek to add General Electric as a party and plead a claim in the alternative under § 301 of the Labor Management Relations Act. This is a protective measure taken in light of the Magistrate's belief that General Electric should be party in this action because Stuart's common law contract claim

"is really" a § 301 claim under the Labor Management Relations Act.[3]

The Plaintiffs have eliminated claims based on common law breach of contract, on the common law doctrine of bad faith, and their claim alleging the common law tort of conversion.

Since the prime concern of Justice O'Connor's opinion is to make sure that specific ERISA *remedies* are the *only remedies* available to plan beneficiaries, the Plaintiffs no longer claim entitlement to punitive damages.

The Plaintiffs' second amended complaint contains only four counts. Count I is a suit for benefits due under the terms of a plan (29 U.S.C. § 1132(a)(1)(b)) and for any additional appropriate relief under 29 U.S.C. § 1109 such as the removal of Metropolitan as a fiduciary because it administered the plan to favor its own interests rather than "*solely* in the interest of the participants and beneficiaries". 29 U.S.C. § 1104(1).

Count III alleges that Metropolitan's practice of offsetting its claimed debt against benefits due or to become due violates

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[3] This should no longer be a relevant issue. It was a conclusion reached only in the context of the Magistrate's analysis of the insurance plan as a "collective bargaining agreement" rather than a contract between Stuart and Metropolitan. Of course, no relevant collective bargaining agreement incorporating the terms of the plan was ever produced. Stuart's common law contract claim is, in any event, preempted by ERISA. There is always, however, the possibility that someone might decide that § 301 of the LMRA pre-empts ERISA, despite the present absence of authority to that effect.

specific New York insurance statutes and is thereby illegal under both New York law and ERISA.[4]

Count II claims that Metropolitan's recoupment practices violate the Social Security Act's exemption of proceeds statute. 42 U.S.C. 407, while Count IV alleges in the alternative to Stuart the Defendants' actions violated § 301 of the LMRA.

III.

ARGUMENT: CONTRACT ANALYSIS: COUNT I

The Plaintiffs maintain, as they always have, that Metropolitan's termination of their benefits was illegal under ERISA because neither the plan itself nor any of the plan documents mention, in any way whatsoever, that they will be in debt and benefits will be terminated because of the receipt of a lump sum Social Security payment. The issue is not what would be reasonable *if* Metropolitan had written the provision it seeks to enforce into the plan, as it later attempted. Rather, Metropolitan seeks to have this Court rewrite the plan to fit its desire. As we will see, however, Metropolitan at all times had language ready at hand to explain what it now contends is the meaning of its plan. The fact that such language was left out of both the plan and the SPD notwithstanding its availability raises a presumption that it wasn't intended to be a part of the con-

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[4] *Dedeaux and Taylor* did not overrule *Metropolitan Life Insurance Company v. Massachusetts*, 105 S.Ct. 2380 (1985) which held that ERISA does not pre-empt state statutes setting substantive standards for insurance policies. New York insurance law (to the extent any state law applies, it is, by agreement the law of New York) regulates the terms of insurance contracts by requiring that they conform to the "requirements and prohibitions" of New York law. New York insurance law § 3103(a). New York insurance law exempts proceeds of any disability policy from "every action, proceeding or process whereby the assets of a debtor may be subject to the claims of a creditor. New York insurance law § 3212. In addition, the regulations of the Department of Labor contemplate the regulation of insurers of ERISA plans by state insurance laws. 29 CFR 2560.503-1(c).

tract.[3] Nonexistant contract provisions are no more enforceable under ERISA than they are under common law. *Hillis v. Waukesha Title Co.*, 576 F.Supp. 1103 (ED. Wis. 1983)("I hold that where a plan participant is reasonably unaware of a benefit forfeiture clause and where the plan administrator fails to take any steps to advise participants of the forfeiture clause . . . [it] may not be enforced against the paticipant." Id. 1109.)

Metropolitan's rejoinder is twofold. First, it claims that the receipt of a lump sum Social Security payment *creates* an "overpayment" or debt with respect to insureds who have been getting unreduced LTD benefits from it. In a sense, Metropolitan claims it is allowed to rewrite history by deeming the benefits it initially paid out as benefits which shouldn't have been paid out, even though under the plain language of the plan Metropolitan was required to make such payments. Its precise obligation under its contract was to pay each month, 50% of an employee's pre-disability income if no other offsettable benefits were being received. *Bush v. Metropolitan Life Insurance Com-*

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[3] The Plaintiffs insistance that the insurance contract and plan terms be enforced as written is not, as Metropolitan suggests, an attempt to "double dip" by getting, however briefly, two forms of disability compensation. The Plaintiffs bought the insurance in the first place to provide *extra* compensation in the event of disability. How much extra is a question that was and should be determined by reference to the policy language and not by deference to Metropolitan's after the fact desire to shift the risk of a delay in the receipt of Social Security payments to its insureds. Also, while extra contractual damages are probably no longer available, it should be remembered that the termination of benefits had serious consequences for the Plaintiffs. Stuart lived his last years in debt and under a cloud of economic anxiety. Circumstances were so reduced that his phone service was cut off on several occasions. Danis suffered also, but to a lesser extent because of a small amount of private savings.

pany 656 F.2d 231 ("at the time of payment the [LTD] benefits were not benefits that 'shall not have been paid' " Id. 233.)[6]

The second prong of Metropolitan's claim is that once the debt arises it should be allowed under the contract terms to collect its claimed overpayment by withholding all benefits due to the insured and applying them to tis own account to make up the so-called debt. This action, however, directly contradicts the terms of the plan because it has the immediate effect of reducing the insureds income to less than 50% of his pre-disability income (Danis' income dropped to $236.33 less than the "assured" 50% of pre-disability income, while Stuart's income sunk below the guarantee line by $215.68). Defendant's response to interrogatory 8 in each appendix.)

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[6] *Bush* held the Metropolitan policy at issue there to be ambiguous and therefore not enforceable against an insured. The *Bush* contract was ambiguous because there was a recoupment provision in it which read:

> If it is determined that any Extended Disability Benefits paid to the Employee under the Group Policy should not have been paid or should have been paid in a lesser amount, the Insurance Company shall be entitled to a refund of the amount of the overpayment." *Bush* and appendix to this memorandum (hereafter "memo appendix") at 24.

The policy/plan here cannot even be said to be ambiguous because there is no recoupment provision at all. As one of Metropolitan's memoranda assessing *Bush* states:

> It was the Court's opinion that at the time Ms. Bush presented evidence that her Social Security Claim had been initially denied, Extended Disability Benefits should have been paid in an unreduced amount, and that she was, *at the time*, entitled to exactly the benefits that Metropolitan paid to her. The Court *specifically* rejected Metropolitan's argument that later developments, such as a retroactive Social Security Award, rendered earlier payments incorrect. In the Court's opinion, "recoupment is permitted only when the insurance company erroneously overpays according to conditions manifest at the time of payment." It was noted that Metropolitan could cure this problem by simply redrafting the clauses in question to clarify the contract's coverage. Memo appendix at 25. (Second emphasis added.)

a. THE PROPER STANDARD OF REVIEW

In view of its own admission that "the plan and policy do not contain language specifically authorizing the recovery of overpayments" (Metropolitan's response to Danis' statement of material facts; paragraph III(5)), Metropolitan must necessarily argue against any standard doctrine of contract interpretation and in favor of being given very broad discretion determining the meaning of the terms of its own contract. In fact, it will have to argue that in recouping benefits it can be permitted to contradict the terms of the plan and to allow the monthly benefits guaranteed to insureds to fall below the 50% level promised in both the plan and the SPD.

It will, in short, argue for the broadest application of the so-called "arbitrary and capricious" standard of review possible — that is to say, no meaningful review at all.

A number of courts have applied some deferential standard of review in certain ERISA cases. In most cases, these courts have paid little heed to the Congressional purpose in enacting ERISA which was to provide increased protection for beneficiaries under pension and welfare plans and to set certain specific *minimum* standards for the administration of those plans. See e.g. *Marshall v. Snyder* 572 F.2d. 894, 901 (1978).

However, almost every court which has applied the arbitrary and capricious standard of review has applied it to the discretionary actions of trustees exercising control over a pension or welfare benefit trust fund. In *Justings v. New England Telephone & Telegraph Company* 757 F.2d. 8, 9 (1985) Prudential Life Insurance Company was merely the administrator of the New England Telephone & Telegraph long-term disability fund. All the money paid out in claims came from funds set aside by New England Telephone & Telegraph and the amount of claim money paid out would have no impact on Prudential's profit or losses. (For a more detailed explanation of the Prudential — NET arrangement see letter from Linda Woodley of Prudential Insurance Company; memo appendix at 1-2.)

Govoni v. Bricklayers, Masons, and Plasterers, 732 F.2d. 250 (1984) also involved a pension trust fund administered by trustees.

Metropolitan, however, is not a trustee nor is any trust fund created from which long-term disability payments are made to General Electric employees. Thus, if the claims against Metropolitan exceed its expectations, it looses money on the policy while if fewer claims than expected are made, or if its payout under the terms of the policy is lower than expected, Metropolitan will realize a gain.

The difference between neutral trustees administering a specific trust fund set aside for the purpose of paying benefits and an insurance company paying benefits under the terms of an insurance contract is critical. Trustees administering a trust fund may have no personal financial stake in the *results* of their administration (or if they do, they face heavy penalities including going to jail). Insurance companies, on the other hand, have a direct financial stake in the claims experience under their policies. The accuracy of their actuarial predictions determine whether they gain or loose money on their contract. It is a business in which there is an inherent conflict of interest between the insurer and the insured.

Metropolitan might suggest there is no real conflict between it and plan beneficiaries arguing that the only effect an increased payout will have is to raise the cost of insurance in later years as Metropolitan recoups prior years losses. However, the group insurance business is very competitive. Businesses can and do change insurers. It is by no means clear that Metropolitan could recoup any losses sustained (or any reduction in profits) if it were not allowed to recoup Social Security benefits from its insureds. The question of whether or not a court may apply a deferential standard of review in favor of one of two interested parties before it is, beyond a doubt, a question of constitutional dimension.

b. A DEFERENTIAL STANDARD OF REVIEW FOR AN INSURERS INTERPRETATION OF ITS CONTRACT VIOLATES THE INSUREDS CONSTITUTIONAL RIGHT TO DUE PROCESS.

There is nothing in ERISA to suggest that Congress intended the Courts apply any deferential standard of review to claims decisions by employee benefit plan fiduciaries. To the extent it is applied, it amounts to a delegation by the Courts of initial judicial authority to ERISA trustees. However, it is constitutionally impermissable to delegate such authority to a fiduciary such as an insurance company who has a direct financial stake in the outcome of its decision. (In fact, the notion of a self-interested fiduciary is contradictory.)

"The rule *nemo judex in re sua,* or tenet that no man is to be a judge in his own cause, was so central a tenet of the common law that Lord Coke insisted [in Dr. Bonham's Case] upon a Court's right to invalidate acts of parliment that ignored it."[7]

This tenet has also been central to this country's notion of due process. *Tumey v. Ohio*, 273 U.S. 510 (1927); *Ward v. Village of Monroeville*, 409 U.S. 57 (1972); *Gibson v. Berryhill*, 411 U.S. 564 (1973) and *Aetna Life Ins. Co. v. Lavoie*, 106 S.Ct. 1580 (1986).

The only serious question is whether or not the interest of the adjudicator in the outcome is significant enough to make his participation in the decisionmaking a denial of due process. However, there is absolutely no disagreement that recusal is in order where an interest is direct, substantial and pecuniary. *Lavoie*, 1588-89.

In this case, which involves the interpretation of contract provisions that apply not merely to the instant Plaintiffs, but to thousands of others, it is clear that Metropolitan's interest is

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[7] Redish and Marshall. Adjudicatory Independence and the Values of Procedural Due Process, 95 Yale Law Journal 454, 480 (Jan. 1986).

"direct, substantial, and pecuniary." Nor is this contention supported merely by a common sense notion of the nature of the relationship between insurer and insured. There is abundant uncontroverted evidence.

The documents attached to the appendix to this memorandum make Metropolitan's stake in its own interpretations amply clear. Ever since the Sixth Circuit Court of Appeals in *Bush v. Metropolitan Life Insurance Company*, supra, held that Metropolitan's contract language was inadequate to sustain its practice of recouping benefits when an insured received a retroactive Social Security payment. Metropolitan has concerned itself with the impact of similar rulings, with keeping information about that ruling from its insureds notwithstanding its status as a fiduciary, and with amending the language of its contracts to permit its practice. There is, for example, the memo from Richard G. Mandell of the Metropolitan Law Department to Donald J. Harmon, the Assistant General Counsel. Mandell notes, "jurisdiction in Bush was based on ERISA. If in future cases, ERISA is held to supersede state law concerning construction of contracts, federal law will govern and we will probably be collaterally estopped. If state law controls and we are either in state court or in a diversity case, we will probably not be estopped." Memo appendix at 3.

The remainder of the Mandell memo is concerned with how to get around *Bush*.[5]

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[5] *Bush v. Metropolitan Life Insurance Company*, supra, applied state contract principles to an action removed under ERISA. There is, in fact, however, no reason why such widely accepted common law principles, such as the principle that ambiguities in insurance contracts should be strictly construed against an insurer, should not also become part of the federal common law of employee benefits, especially in light of ERISA's mandate that federal courts develop a common law. *Murphy v. Heppenstall Co.*, 635 F.2d. 233, 237 (3rd Cir. 1980). The policy considerations are the same whether insurers sell and administer insurance under large group policies or individual policies. The insurers *interest* will always be opposed to the claimants interest. It is a situation quite different from the usual ERISA case in which a trustee administers a trust fund.

Other memoranda also make Metropolitan's interest embarrasingly clear. According to John Kay "this is a Michigan case with *enormous impact* on our EDB-LTD business." (Emphasis added.) Memo appendix at 4.

B.J. Villa, a Metropolitan actuary urges modification of "all our LTD contracts to reflect the wording suggested by Mr. McEvoy . . . I will take the responsibility that *this is in Metropolitan's financial interest*". Memo appendix at 9. (Emphasis added.)

There is further the assessment that the loss Metropolitan might face under a class action suit brought under the General Motors contract would be approximately $3,000,000.00. Memo appendix at 5-7. Even in these times, that is a substantial pecuniary interest.

Perhaps Gerald Marrinan put it most succinctly when he said "this particular problem is a warm stick of dynamite glowing in the woods about to go off at any time." Memo appendix at 8.

While Metropolitan was concerned with protecting itself (according to Jack Whitestone "the court said that we could protect ourselves in the future by 'explicitly adding a recoupment provision to the contract to cover such circumstances.' " Memo appendix at 47-48), no thought was given to stopping the practice of recouping insurance benefits under contracts which did not explicitly provide for such recoupment. Nor was Metropolitan in any hurry to modify its contract or SPD's. Rather, "no across the board change is anticipated, for fear of creating more problems than are solved. i.e. a general distribution might trigger additional lawsuits and/or requests for *refunds of SS awards* which were retroactively carved out." Memo appendix, 10. (Emphasis added.)

Clearly, if this Court, or any Court for that matter, had at stake the interest that Metropolitan has in a favorable interpretation of its contract provisions, it would have to recuse

itself. However, precisely what Metropolitan is asking this Court to do by upholding its decision as to the meaning of its contract, notwithstanding the absence of language describing its intentions, is to accord its decision the deference of the "arbitrary and capricious" standard of review. That, however, would allow Metropolitan to become the first, and because of the deference accorded, the most important adjudicator in its own case. Under such circumstances any deference to Metropolitan's interpretation of its own contract would be constitutionally impermissable. A Court simply cannot delegate to private parties an adjudicatory function under circumstances in which it would be constitutionally impermissable for the Court itself to exercise decisionmaking power. (Of course, even if the issue is not viewed as involving the *delegation* of an adjudicatory function, the *unequal treatment* of interested litigants still denies due process.)

C. THE APPLICATION OF TRUST LAW CONCEPTS ALSO PRECLUDES A DEFERENTIAL STANDARD OF REVIEW.

Finally, judged even under trust law standards, Metropolitan must lose. The deference of trust law only applies to discretionary functions, such as deciding how to invest trust income when the trust document is silent on the subject. III Scott on Trusts, § 187. If, however, the trust document says $1,000.00 per month must be paid to my daughter each month so long as she shall live the trustee is not free simply to withhold that amount (so long as the trust has money).

Trustees have always been required to enforce the specific terms of a trust, nor may they invent new terms not required by the trust (*especially* if its to serve the trustees own interest). *Morgan v. Mullins*, 643 F.2d. 1320, 1321 (8th Cir. 1981) ("Where the trustees impose a standard not required by the pension plan itself . . . such action would result in an unwarranted and arbitrary construction of the plan.")

Also, "the most fundamental duty owed by the trustee to the beneficiaries of the trust is the duty of loyalty." II Scott on Trusts 170.

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Remainder of brief omitted as not relevant to this petition.